

DOCUMENT RESUME

ED 192 993

RC 012 295

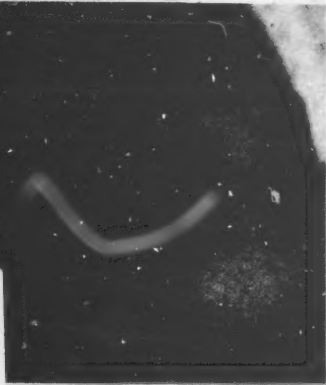
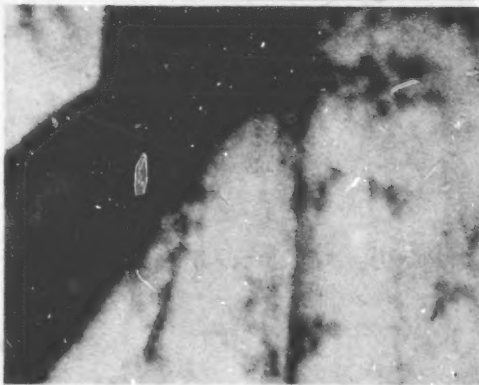
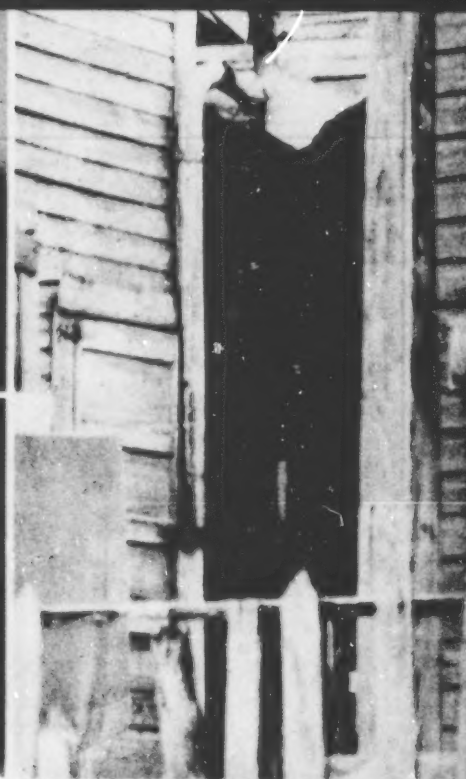
AUTHOR Ramirez, David G.
 TITLE A Review of the Literature on the Underutilization of Mental Health Services by Mexican Americans: Implications for Future Research and Service Delivery.
 INSTITUTION Intercultural Development Research Association, San Antonio, Tex.
 SPONS AGENCY National Inst. of Mental Health (DHEW), Rockville, Md.
 PUB DATE 80
 GRANT MH-31212-02
 NOTE 74p.; Not available in paper copy due to publisher's preference. For related documents, see RC 012 296-297.
 AVAILABLE FROM Intercultural Development Research Association, 5835 Callaghan Road, Suite 350, San Antonio, TX 78228 (\$6.00).
 EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
 DESCRIPTORS *Community Health Services; Community Resources; Counseling Services; Cultural Differences; *Delivery Systems; Ethnicity; Mental Health Clinics; *Mental Health Programs; *Mexican Americans; Models; *Needs Assessment; Spanish Speaking; *Use Studies
 IDENTIFIERS Faith Healing

ABSTRACT

Reviewing the research findings and issues which have been generated around the topic of Mexican American underutilization of mental health services, this paper discusses five major concepts: (1) the epidemiological paradox of Mexican American underutilization of services; (2) explanation offered for the paradox; (3) elaboration on the explanation of incompatibilities of services; (4) examination of the conceptual problems involved in underutilization; and (5) discussion of recommendations for change. The paper discusses the findings which revealed that underutilization is not homogeneous; the concept of utilization is quite complex, and measures of need, accessibility and quality of services are needed to interpret utilization rate findings; and the concept of the existence of incompatibilities between the service delivery system and the characteristics of the clients holds the most conceptual promise. A two-tier approach is suggested which emphasizes both the concepts of equity and compatibility between clients' needs and the services provided. It is recommended that more research be done on total systems, including community involvement, funding agencies, service facilities, providers, and clients. (Author/JD)

 * Reproductions supplied by EDRS are the best that can be made *
 * from the original document. *

ED192993



RC 01 2295

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

"PERMISSION TO REPRODUCE THIS
MATERIAL IN MICROFICHE ONLY
HAS BEEN GRANTED BY

Mary Binder

TO THE EDUCATIONAL RESOURCES
INFORMATION CENTER (ERIC)."

IDRA BOARD OF DIRECTORS

Chairperson of the Board
Mr. Jesse Treviño
McAllen, Texas

Mr. Othon Medina
El Paso, Texas

Vice-Chairperson
Mrs. Jan Coggeshall
Galveston, Texas

Mr. Fernando Piñon
Laredo, Texas

Secretary
Mrs. L. Debbie Haley
Houston, Texas

Mr. Jesse Rangel
Lubbock, Texas

Dr. James A. Forester
San Antonio, Texas

Ms. Tina Reyes
Houston, Texas

Mr. Jose Antonio Gonzalez
Fort Worth, Texas

Mr. Mauro Reyna
Austin, Texas

Mr. Mike Hernandez, Jr.
San Antonio, Texas

Mr. Lanny Sinkin
San Antonio, Texas

Mr. James D. Lehmann
Eagle Pass, Texas

Mr. William Sinkin
San Antonio, Texas

Dr. José A. Cárdenas
Executive Director

IDRA is a non-profit, tax-exempt organization, the purpose of which is to provide information to the general public concerning equality of educational opportunity.

Front cover design by Mary Binder and David Ramirez

**A Review of the Literature on the Underutilization
of Mental Health Services by Mexican Americans:
Implications for Future Research and Service Delivery**

by

David G. Ramirez

Copyright © 1980 by Intercultural Development Research Association

This publication was produced with funds from a grant (MH 31212-02) made to the Intercultural Development Research Association (IDRA), by the National Institute of Mental Health (NIMH). However, the opinions expressed herein are solely those of IDRA and do not necessarily reflect the position or policies of NIMH, and no official endorsement should be inferred.

ABSTRACT

This present paper will present the research findings and issues which have been generated around the topic of Mexican American underutilization of mental health services. The discussion is divided into five major sections: 1) the presentation of the primary issue - the epidemiological paradox of Mexican American underutilization of services, 2) the explanations offered in the literature for the paradox, 3) an elaboration of the incompatibilities of services explanation, 4) an examination of the conceptual problems involved in underutilization, and 5) a discussion of the recommendations for change offered in the literature.

Four general conclusions were reached by the present author. First, the underutilization phenomenon is not a homogeneous finding in the literature, and in some cases, overutilization is found. This is particularly evident in centers where an attempt has been made to provide Mexican American clients with compatible services. Second, the concept of utilization is quite complex, and in the absence of measures of need, accessibility and quality of services, it becomes difficult to interpret utilization rate findings. Third, among the diverse explanations offered for the underutilization paradox, it appears the concept of the existence of incompatibilities between the service delivery system and the characteristics of the clients holds the most conceptual promise. Finally, a two-tier approach is suggested as the focus of future advocacy efforts in the area of the improvement of mental health services for Mexican Americans. This approach emphasizes both the concept of equity (equal accessibility and availability of services) and the concept of compatibility between the clients' needs and the services provided (the provision of appropriate and acceptable services).

PREFACE

Like most ventures of its type, this paper evolved from the author's experience, biases, and the current state of the art. The state of the art in this area is indeed in a curious position, in that only a small amount of research has been conducted and yet a wealth of issues have surfaced. The present author will stress that during our continued quest for knowledge in this area, we must begin to take note of and address the many critical issues we have raised in past research. Many of these issues will no doubt stir considerable controversy if they have not already. As examples, consider: 1) the importance of curanderismo in the present day delivery of mental health services to Mexican Americans (Is it a key to attracting the community to services or a concept which has been buried in time?), 2) the societal view of the Mexican American family (Is it a bastion of strength or a source of tremendous stress?), and 3) the increased utilization of services by Mexican Americans as a goal of advocacy efforts (Will increased utilization of existing services and modalities bring our communities better "mental health" or should efforts focus on the revamping of the system of care to meet the needs of Mexican Americans, with the assumption that the provision of more appropriate services will lead to greater utilization?). In dealing with many issues of this type, minority researchers have all too often found themselves perpetuating some of the same myths and biases founded by researchers of the majority population. We must caution against this tendency and consider carefully the policy implications of our work.

Along with this struggle with the conceptual and methodological issues involved, future research will need to face an ever increasing demand from the community, particularly the Mexican American community, for relevance in research. The Mexican American community is beginning to ask to see the payoff of all this research and we had better be prepared to respond effectively. Funding for research in this area has been minimal and may even be decreasing in the face of governmental budget cuts. Nevertheless, if our country's mental health institutions are to begin to effectively serve its Mexican American citizens, then extensive research efforts must continue in the development of culturally compatible systems of service and care.

It is interesting to note those occasions in history when the demands of a minority for relevance and responsiveness from its country's institutions are followed by similar demands on the part of the majority. Community mental health and mental health delivery systems as a whole are currently an excellent example of such an occasion. There is and will continue to be a demand from the consumers of mental health services for a greater degree of responsiveness to their individual needs. The true difficulty lies in whether or not the present mental health establishment possesses the technology and resources to become more adaptive and responsive. The present author will assert that it does not, but that a sincere commitment to achieve the necessary resources and technology can prove successful. Such an effort will require research, community involvement, and an openness on the part of the mental health establishment to the concept of change.

Although such a recommendation is not rare, it will be argued that it has seldom if ever been effectively implemented. Too much research has been unrelated to the real life needs and situations of its subjects. All too often, community involvement has been minimal on the part of the community and ignored rather than fostered by our institutions. Finally, in the face of a funding crisis, increasing demands for effective and appropriate services by a range of groups, and a serious lack of technology, the mental health service delivery systems, particularly the community mental health system, have begun to erect barriers of bureaucracy between themselves and their consumers under the pretext of protecting themselves. As many organizational researchers would agree, such a move on the part of these systems can only result in maladaptive results.

This paper was thus written in a truly pivotal period for the future of mental health in America. The paper was designed to achieve two specific goals: 1) to present the literature on this topic in the context of a discussion of the issues rather than the methods and specific findings obtained, and 2) to attempt to display the continuing urgent need for extensive research in this area. As this paper is one in a series to be produced by the Mental Health Research Project, the content at times will reflect our particular interest in the Texas mental health service delivery system. The reader must be the judge of the generalizability of the issues raised to his or her own specific community.

Since the original version of this paper was drafted, many of my friends have helped with its reformulation. I would like to acknowledge the support and insights provided me by Dr. Ramiro Valdez, Ms. Maria del Refugio Robledo, Ms. Sharon Hassell, Ms. Bernadette A. Brusco and Ms. Mary Binder. I would like to give particular thanks to Dr. Jose Cardenas, for his confidence and support, Dr. Sally J. Andrade, whose skillful editing and numerous insights proved to be a tremendous resource in my efforts, and Ms. Rosario Trejo, for her undaunted perseverance in typing the numerous versions through which this paper evolved.

MENTAL HEALTH RESEARCH PROJECT OF THE
INTERCULTURAL DEVELOPMENT RESEARCH ASSOCIATION

The Intercultural Development Research Association's Mental Health Research Project (MHRP), funded by the National Institute of Mental Health, seeks to improve mental health delivery systems for Mexican Americans in the state of Texas.

The MHRP's major goals include: 1) a preliminary analysis of the effectiveness of the state mental health service delivery system and subsystems in providing services to Mexican Americans; 2) an assessment of the community mental health center concept as it relates to the Mexican American population; 3) the design of a bilingual/multicultural human service delivery model relevant to the mental health needs of Mexican Americans in Texas; and 4) the development of policy and programmatic alternatives to enhance the utilization of the state mental health service delivery system by Mexican Americans.

The MHRP has established a Texas Advisory Committee which consists of mental health service deliverers, professionals/academicians and consumer representatives from the five major geographical regions of Texas. The committee members serve as conduits for information dissemination and collection. To ensure maximum generalizability of the process and products of the MHRP, six nationally recognized professionals in the area of mental health and service delivery systems serve as consultants to the MHRP in the form of a National Advisory Committee.

The goal of the IDRA Mental Health Research Project is improved services for Mexican Americans in the state of Texas. Because a lack of agreement has existed in Census surveys and social science research as to the definition of a "Mexican American," potential problems emerge in attempting to compare data sources across regions or time frames. Terms encountered historically to identify this ethnic group include: Mexicans, Mexican Americans, Spanish-surnamed, Spanish-speaking, Latin Americans, Spanish Americans, Hispanics, etc. The term "Mexican Americans" is used consistently by the Mental Health Research Project to refer to this population, indicating those residents who are of Mexican origin or descent. References to specific data sources may at times utilize the exact label cited therein (e.g., "Spanish Americans"); it is assumed by the project that the overwhelming majority of any such individuals in Texas are of Mexican origin.

Mental Health Research Project Staff

David G. Ramirez
Ramiro Valdez, Ph.D.
Bernadette A. Brusco
Sharon S. Hassell, A.C.S.W.
Criselda S. Price, M.A.
Janice Pape
Sally J. Andrade, Ph.D.
Rosario H. Trejo

Project Director
Research Coordinator
Research Scientist
Field Researcher
Research Assistant
Data Analyst
Project Evaluator
Project Secretary

TABLE OF CONTENTS

	Page
Introduction	1
I. The Epidemiological Paradox of Mexican American Underutilization of Mental Health Facilities	2
II. Explanations Offered in the Literature for the Existence of the Underutilization Paradox	9
III. Incompatibilities of Services as an Explanation for Underutilization	23
IV. The Concept of Underutilization in Research	27
V. Recommendations and Models Found in the Literature for Enhancing the Utilization of Mental Health Services by Mexican Americans	38
Conclusion	50

In the recent past, the mental health establishment and the federal government began acknowledging that minority populations have special needs in the area of mental health; many of which are going unmet. Public Law 94-63 mentioned the need for services to be provided to linguistically different groups, and the Mental Health Systems Act currently under debate in Washington also makes reference to the need to provide services appropriate to the needs of special populations. The time span between acknowledgement and action has been and continues to be of considerable interest to many minority communities and researchers. There exists in our country an increasing interest on the part of all our citizens in gaining a better understanding of exactly what services are being provided by our institutions, at what cost, and with what results. The over nine million Mexican American citizens of the United States are increasingly becoming involved in gaining answers to these questions in reference to their communities.

Among the many critical research issues involved in studying the relationship between, the Mexican American and the mental health service delivery system, few are so basic as an assessment of their past and present patterns of utilization of existing services. A considerable body of literature has been generated around this subject such that an assessment of the critical issues involved can now begin.

Thus, the purpose of this paper is to review the current literature pertaining to Mexican American utilization of mental health services. Given the existence of a number of excellent reviews on this topic (Padilla & Ruiz, 1973; Padilla, Ruiz & Alvarez, 1975; Barrera, 1978) this paper will take a different, possibly more evaluative tenor than has been feasible in the past. The discussion will be divided into five major sections: 1) a definition of the epidemiological paradox of underutilization of mental health services by Mexican Americans; 2) an assessment of the major explanations proposed by numerous researchers for this paradox; 3) a discussion of the appropriateness or compatibility of mental health services for Mexican Americans; 4) an evaluation of underutilization as a concept in research; and 5) an analysis of the recommendations and models suggested for improving mental health services for Mexican Americans.

I. The Epidemiological Paradox of Mexican American Underutilization of Mental Health Facilities

For well over two decades, researchers have struggled with the epidemiological paradox of Mexican American underutilization of mental health services. The life experience of the majority of Mexican Americans has been characterized by discrimination in education and employment, by substandard housing, and by poverty. Researchers, such as Hollingshead & Redlich (1958) and Srole, Langer, Michael, Opler, & Rennie (1962), have documented a significant direct relationship between poverty and mental illness which posits that higher levels of poverty correlate with

a higher incidence of mental illness. Others have suggested that the experiences of acculturation and migration, two other factors that have affected Mexican Americans, are also directly related to a higher incidence of mental illness (Papajohn & Speigel, 1976). Given that Mexican Americans experience the stress of poverty and acculturation and that there is probably a strong relationship between these factors and mental illness, one would expect that higher rates of mental illness would be evident in the Mexican American population and, hence, generate a higher utilization of mental health services by this group.

The paradox is that numerous studies have found a significant underutilization of mental health facilities by Mexican Americans (Jaco, 1959; Karno & Edgerton, 1969; Kruger, 1974; Bachrach, 1975; Carlos & Keefe, 1976; Sue, 1977; Cuellar, 1977). The following summary by Barrera depicts the fairly broad geographic dispersion of research efforts in which the underutilization phenomenon has been obtained:

Patterns of underutilization have been reported for California state mental health facilities (Karno & Edgerton, 1969); a San Jose, California, mental health center (Torrey, 1973); Denver facilities (Kline, 1969); services in Colorado and New Mexico (Weaver, 1973); Texas State Mental Hospitals (Pokorney & Overall, 1970); and community mental health agencies in Seattle, Washington (Sue, Allen, & Conaway, in press).

A national survey of admissions to inpatient services of state and county mental hospitals was consistent with the reports from individual states and communities (Bachrach, 1975). Based on estimates projected from a 1972 sample, Bachrach found that Spanish-Americans had lower utilization rates than other whites and nonwhites (155, 181, and 334 per 100,000 of population, respectively). (Barrera, 1978, p. 36)

The history of this paradox of underutilization begins with a study by the sociologist Jaco (1959). He conducted a comprehensive study of first admissions into Texas state hospitals during the years 1951 to 1952. Jaco's results indicated that only six percent of the 11,298 psychotic cases admitted during this period were Spanish-surnamed, compared to 84.6 percent Anglos and 9.4 percent Blacks. Jaco concluded that Mexican Americans utilized services to a lower degree and that possibly this was due to the strong emotional support provided by the Mexican American extended family.

In a later study conducted in California, Karno & Edgerton (1969) found that although Mexican Americans comprised approximately 10 percent of the total population, they represented "only 2.2% of State hospital admissions, 3.4% of State Mental Hygiene Clinic admissions, 0.9% of Neuro-psychiatric Institutes (state centers for teaching and research) outpatient admissions, and 2.3% of inpatient admissions to state-local joint supported facilities" (Karno & Edgerton, 1969). The authors pointed out that the "expected figure in each of the preceeding instances would be 9% to 10%."

Kruger (1974) analyzed data from the Texas Department of Mental Health and Mental Retardation (TDMHMR), and underutilization was found here also. When comparing utilization rates from twenty-four community mental health mental retardation centers and state hospitals, Kruger found that of fourteen comparisons which indicated significant ethnic differences, Mexican American were underrepresented at state hospitals. Kruger also noted that in eleven of these fourteen significant comparisons, Blacks were overrepresented. It should be noted that in Kruger's study, utilization of service was not broken down by the various service categories of mental health, mental retardation, alcoholism and drug abuse. This is of particular importance in that in a subsequent study utilizing TDMHMR data from 1976 for Texas state hospitals and community mental health mental retardation centers, Cuellar (1977) also found significant ethnic differences within service categories. Cuellar further found Mexican Americans underrepresented in mental health and alcoholism services, while they were overrepresented in mental retardation and drug abuse services when compared to Anglos and Blacks.

In a study by Ramirez (1979), again utilizing data from the Texas Department of Mental Health and Mental Retardation, a highly significant effect for socioeconomic status was obtained. Lower income individuals utilized services at a far greater rate in state hospital facilities than individuals in higher income groups. After controlling for the age, sex and socioeconomic status of the users of mental health services, differential

utilization by ethnicity was not found. As such, the variable of socioeconomic status is clearly of critical importance in attempting to understand the concept of utilization of mental health services.

In yet another analysis of data from the Texas Department of Mental Health and Mental Retardation, Fiedler (1979) generated utilization rates per thousand by ethnicity for each of the twenty-nine community mental health mental retardation centers in Texas. Although a statistical analysis of the rates was not performed, the pattern of results was clear. Some centers were utilized at numerically equivalent rates by Mexican Americans in comparison to Anglos and Blacks, and yet in other areas Mexican Americans again displayed the underutilization phenomenon. Fiedler's study and those of other researchers (Trevino & Bruhn, 1977; Ramirez, 1979; Wignall & Koppin, 1967) document that underutilization of mental health services by Mexican Americans is not a homogeneous finding. There are cases where numerically equivalent rates of utilization by Mexican Americans are obtained. In fact, studies exist which document higher rates of utilization by Mexican Americans relative to non-Mexican Americans (Wignall & Koppin, 1967). It is important to note though, that in many of the studies citing a higher rate of utilization by Mexican Americans, some form of adaptation had been implemented by the service delivery system to become more responsive to Mexican American clients (Phillipus, 1971; Burrue! & Chavez, 1974; Trevino & Bruhn, 1977; Flores, 1978). The possible causal link between responsiveness of the service

delivery system to the needs of its clients and greater utilization of services will be explored further in this paper. For now, suffice it to say that it is extremely important to begin to attempt to determine the critical differences between those centers which are and are not utilized by Mexican Americans.

Many of the studies cited previously contained some major methodological shortcomings that should be noted. Jaco's analysis focused only on cases involving psychosis, and, as Cuellar's data indicated, ethnic differences may exist in the varied manifestations of mental illness. In addition, Jaco's data, which were collected in the 1950s are now dated. Karno & Edgerton, on the other hand, did not control for age differences in the population of California which was used as the comparative base for utilization percentages. Furthermore, the majority of these researchers did not control for socioeconomic status when comparing the population of an area with the users of mental health services from that area. This is a particularly important omission as it is possible that the underutilization by Mexican Americans as an ethnic group is the result of class or socioeconomic factors.

There may also be some statistical limitations in much of the previous research which should be mentioned. For example, Karno & Edgerton's data are somewhat suspect, in that they compare a base population figure of 10 percent Spanish-surnamed with the 2.2 percent state hospital admissions. If the core of the Spanish-surnamed population is concentrated in one portion of

the state, there is the possibility that they might overutilize a particular hospital located in that area and underutilize the remaining state hospital facilities located throughout the state. A very gross analysis of only comparing overall state population figures to overall hospital utilization figures will in all probability not provide an accurate assessment of the utilization of each facility. In essence, research in this area is far more accurate if the state or community is divided into smaller segments which are studied individually and in relation to other segments.

Kruger and Cuellar both performed a large number of chi square comparisons in their studies, which predisposes many of the resulting comparisons to having achieved significance by chance alone.

Despite these shortcomings, this avenue of research has led social scientists to ask the critical question of how Mexican Americans are utilizing mental health services. These studies were briefly discussed since they could be seen as representative of the majority of studies that have documented the underutilization effect. The basic approach of each of these studies has been to compare the population of a particular geographic area with the number of users of mental health services - during a specific time period - which are available within this geographic area. The greater the deviation of the percentage of users of mental health services from the percentage of individuals of that ethnic group in the total population in the area, then the greater the amount of "over" or "under" utilization is assumed.

Aside from the methods used in each, these studies as a whole appear to present two basic points: 1) the utilization of mental health services is a concept which is far from simplistic; therefore, controls for age, sex and socioeconomic status must be employed if valid comparisons are to be made across ethnic groups, and 2) the underutilization phenomenon is not always obtained for Mexican Americans.

II. Explanations Offered in the Literature for the Existence of the Underutilization Paradox

Assuming that the paradox of underutilization exists, it is interesting to examine the explanations that are given for its existence. Numerous researchers have presented explanations for underutilization. All too often, however, they have stressed only a narrow range of these possible explanations (that is, those they felt were most viable). For our purposes, it is preferable to review and evaluate the widest range of proposed explanations.

Karno & Edgerton (1969) comprehensively document the major explanations provided by researchers and practitioners for the existence of the Mexican American underutilization phenomenon. The present discussion will use their set of explanations as a reference point. To provide a conceptual background, the three major explanations offered by Karno & Edgerton will be discussed and then followed by a brief analysis of each.

The first explanation offered is that Mexican Americans suffer less mental illness, possibly due to the strong familial support found in the Mexican sub-culture.

The second major explanation is that Mexican Americans suffer as much as, or more, from psychiatric disorder than do Anglos, but that the disorder may be less visible because it is expressed in criminal behavior, narcotics addiction, or alcoholism.

Finally, the third explanation, and the one they elaborate into seven sub-explanations is that psychiatric disorder among Mexican Americans is expressed in the way other ethnic groups express it, but is less visible due to a variety of reasons:

1. Mexican Americans perceive and define psychiatric disorder differently than do Anglos. Specifically, they are more tolerant of idiosyncratic and deviant behavior and hence are less likely to seek professional help. A common variation of this viewpoint is expressed in the belief that Mexican Americans are simply ignorant about what more educated persons know, viz - the signs and symptoms of mental illness: they are also presumed to be ignorant about why or how to seek professional help. This is seen (by some who cite this view) as being largely a reflection of the very limited development of mental health resources and education in Mexico itself.
2. Mexican Americans are too proud and too sensitive to expose more personal problems to public view; they feel too much shame or stigma attached to an admission of need for professional mental health assistance. One variety of this view stresses the long prior history of humiliation experienced by Mexican

Americans in their relationships with Anglo agencies and institutions. Another stresses the conservative, rural value system of the Mexican American.

3. Clinics and hospitals which offer psychiatric services do not operate in ways which fit the needs of Mexican Americans and hence are little used by them. For example, the cost is too high, the distance too far, the hours are inappropriate, and the staff do not demonstrate respect, promote self-dignity, nor evidence cultural sensitivity.
4. In place of formal mental health services Mexican Americans utilized the services of priests, family physicians, and other persons for psychiatric disorders.
5. Mexican Americans who develop psychiatric disorder frequently return to Mexico to re-establish kinship or other emotionally supportive ties or to seek folk or professional help in a familiar context.
6. Mexican Americans who are citizens of Mexico, or who are U.S. citizens but have family members in the United States (legally or illegally) who are Mexican citizens, avoid any contact with the "establishment" which may threaten the security of their (or their relatives') presence in the United States.
7. The majority of Mexican Americans speak only Spanish, or prefer to or can only communicate in Spanish concerning intimate or affectively charged matters; there are very few or no personnel in mental health facilities who speak Spanish. (Karno & Edgerton, 1969, p. 234-235)

As discussed earlier, the first major explanation offered for the phenomenon of underutilization is that Mexican Americans suffer less mental illness, possibly due to the strong familial support system found in the Mexican subculture (Jaco, 1959; Madsen, 1964). These strong familial ties (which are often

simplistically interpreted by some as not existing in Anglo and Black cultures) presumably insulate the Mexican American against the onset of mental illness. In the event that a member of the family is afflicted with mental illness, the Mexican American family tends to protect the individual from contact with Anglo service institutions. In some ways, this explanation for underutilization has relied upon a stereotypic portrait of both the Anglo and the Mexican American cultures that has conceptualized the Anglo family as cold, yet aggressively achievement-oriented and the Mexican American family as warm, yet passive and fatalistic. In a recent study by Keefe, Padilla, & Carlos (1979), comparing the Mexican American family support system to that of Anglos, the researchers arrived at the following conclusions:

In sum, although our research shows that Mexican Americans rely greatly on familial support there is no indication that this is a uniquely Mexican American trait. In fact, the portrait of the isolated Anglo seems dubious at best...

Therefore there is little reason to believe that the presence of the extended family can be the reason for an alleged lower incidence of mental illness among Mexican Americans.

...With this in mind, rather than accentuating the strength of the Mexican American extended family, as opposed to the Anglo extended family and its superiority in the alleviation of emotional problems, we might better emphasize the intensified isolation and stress experienced by those Mexican Americans who lack supportive families and the implications this has for treatment. (Keefe, Padilla, & Carlos, 1979, p. 151)

Saenz (1978), addressing the notion that Hispanics might be better prepared to tolerate stress and hence have lower rates of mental illness, states:

... these rationalizations tend to originate not from evidence, but from a lack of interest on the part of the therapist toward Hispanic consumers, a lack of interest based on little or no understanding of their problems and cultural adaptations. (Saenz, 1978, p. 12)

Because of the lack of evidence that the Mexican American family can lower the incidence of mental illness among its members, such an explanation for the underutilization phenomenon appears implausible.

The second major explanation discussed by Karno & Edgerton for the underutilization phenomenon is that Mexican Americans manifest psychiatric disorder differently than do Anglos. A correlary of this explanation is that mentally ill Mexican Americans may be channeled to different institutions (prisons) than Anglos (private psychiatrists). Morales (1971) describes both the viability of the explanation of differential manifestation of mental illness and its conceptual problems as follows:

While Mexican Americans are under-represented in California State Hospitals (3.3%), they are vastly overrepresented in prison. Of 40,000 adult parolees and prisoners in California, 20% or 8,000 are Mexican American, primarily for offenses related to narcotics. At the California Rehabilitation Center, a state prison facility for narcotic users which has 2,700 prisoners, 44% or 1,188 of the inmates are Mexican Americans. Does this suggest that Mexican Americans utilize narcotics more than other groups? Facts lead one to a different conclusion. It has been known for several years that physicians and nurses comprise the largest single group of narcotic addicts in the country but the record shows this group to be grossly underrepresented in the arrest and conviction columns. This is just another dramatic example of class discrimination and institutional racism. (Morales, 1971, p. 214)

Given the present dearth of comprehensive analyses of Mexican American utilization of a range of social facilities ranging from prisons to treatment centers for mental health and drug abuse, this explanation for the underutilization phenomenon remains a questionable possibility. Again, caution must be expressed that this explanation of differential manifestation does not imply that Mexican Americans are inherently prone to criminal activity, whereas Anglos tend to be neurotic. Rather, the interaction between society and the individual largely determines what form of deviation he or she will demonstrate, as well as who will interact with him/her (police vs. psychiatrist) regarding this behavior.

The third major explanation discussed by Karno & Edgerton is that psychiatric disorder among Mexican Americans is expressed in the way other ethnic groups express it, but is less visible due to a variety of reasons. The authors divided this general explanation into the seven sub-explanations previously listed.

The first variation of the third major explanation cited by Karno & Edgerton, posits that Mexican Americans perceive and define mental illness differently than Anglos. "Specifically they are more tolerant of idiosyncratic and deviant behavior and hence are less likely to seek professional help" (Karno & Edgerton, 1969, p. 234). A study conducted by Karno & Edgerton in two East Los Angeles communities consisted of a survey which was administered in Spanish, as well as English, depending upon the preference of the subject. During one phase of the interview, the respondents read a series of vignettes describing imaginary individuals, in everyday language, who were suffering from some form of mental disorder. Surprisingly, the researchers reported:

Mexican Americans more than twice as often as Anglos, spontaneously replied that the woman was ill. When questioned as to what kind of illness it was, Anglos tended to call it "mental" illness, whereas Mexican Americans called it a "nervous" or "emotional" illness. Mexican Americans were more likely than Anglos to recommend that the woman see a physician.

...both groups recognized to a high degree that she had a serious problem which required professional help.

When asked, "As far as you know does a psychiatrist really help the people who go to him?", Mexican Americans somewhat more than Anglos said yes. Mexican American respondents were also somewhat more optimistic than Anglos about the curability of mental illness. (Karno & Edgerton, 1969, p. 237)

These findings led the authors to the conclusion that underutilization of psychiatric facilities by Mexican Americans "is not to be accounted for by the fact that they share a cultural tradition which causes them to perceive and define mental illness in significantly different ways than do Anglos" (Karno & Edgerton, 1969, p. 237).

An additional comment should be made about the following variation of the explanation of an alternative perception of mental illness:

...the belief that Mexican Americans are simply ignorant about what more educated persons know - viz - the signs and symptoms of mental illness; they are also presumed to be ignorant about why or how to seek professional help. This is seen (by some who cite this view) as being largely a reflection of the very limited development of mental health resources and education in Mexico itself. (Karno & Edgerton, 1969, p. 234)

The implication that Mexican Americans come from a heritage which is unaware or unskilled in the area of mental health is ludicrous, as Morales (1971) indicates:

The first hospital for the mentally ill was founded in Mexico City in 1567. The first hospital for the mentally ill was not founded in the United States until 1732 in Philadelphia - one hundred and sixty-five years later!...

The Aztecs had an amazing grasp of psychology and translations of their documents show that they developed concepts about ego formation and psychic structure similar to those advanced by Sigmund Freud almost five hundred years later! (Morales, 1971, p. 212-213)

The second variation discussed by Karno & Edgerton is that "Mexican Americans are too proud and too sensitive to expose more personal problems to public view..." This explanation suggests that pride and sensitivity and the issue of stigma with reference to mental illness are less significant in Anglo and Black communities, which is highly dubious. In addition, the stereotypic image of the Mexican American as fatalistic, macho and rural is again invoked to explain non-participation in mental health services. As the studies cited earlier by Karno & Edgerton (1969) and Keefe, Padilla & Carlos (1979) pointed out, Mexican Americans are no more or no less perceptually predisposed than Anglos to recognize and disclose mental illness. Advocates of this explanation seem to prefer to place the blame for underutilization on some highly exaggerated and empirically questionable characteristics of Mexican American culture which simply do not appear to be justified.

The third variation that follows on Karno & Edgerton's list will be bypassed for the moment, as its analysis might best be joined with the seventh.

The fourth variation on the list is that Mexican Americans prefer the services of priests and physicians to those of formal mental health providers. Although Keefe, Padilla & Carlos (1979) in their survey analysis of three communities in California, reported higher utilization by Mexican Americans of physicians and clergyman as compared to Anglos, they found that Anglos also utilized these resources. Keefe et al. also reported a higher utilization of friends for emotional support by Anglos than by Mexican Americans. These findings do not appear to support the assumption that Mexican Americans are simply utilizing a different care system than Anglos. In fact, both groups tend to utilize informal support systems much more than formal mental health facilities. This explanation for the underutilization phenomenon must remain tentative at best. Nevertheless, it is possible that the services provided by physicians and priests are preferred by Mexican Americans because these helpers are perceived as more relevant and responsive to their needs and possibly more accessible than institutional services.

The fifth variation listed by Karno & Edgerton is best discussed in two parts: 1) the suggestion that Mexican Americans who develop psychiatric disorder return to Mexico for treatment, and/or 2) therefore, that they utilize folk healers. The notion that mentally ill Mexican Americans return to Mexico is of particular interest when it is juxtaposed with the earlier discussion that Mexican Americans are less capable of perceiving their own illnesses and are also reluctant to seek assistance.

The present explanation asserts that not only do mentally ill Mexican Americans recognize their illness, but they even make a journey a considerable distance back to Mexico for treatment. Given the lack of empirical data to support this hypothesis, this explanation must be labeled somewhat doubtful. It is possible that along the border of the Southwestern United States this may be a factor, but, again, without supportive data, it remains mere speculation. Once again, this explanation fixes the cause for underutilization on a characteristic of the Mexican American, in this case their hypothesized preference for Mexican facilities, rather than the possibility of their perhaps accurately negative assessment of United States facilities.

The second component of this explanation involves the issue of Mexican American utilization of folk healers or curanderos. Kiev's study (1968) of the Mexican American population in San Antonio, Texas, and their utilization of curanderos is one of the most extensive studies currently available (and yet this study is replete with methodological and conceptual problems) which asserts the importance of curanderismo to Mexican Americans. A subsequent study by Torrey (1970) also asserting the importance of curanderismo in the mental health care of Mexican Americans noted that curanderos are widely used, particularly by older Mexican Americans. Torrey pointed out that these indigenous folk healers are often forced to hide from the police and tax agents, thus making research on their activity particularly difficult. Ayala (1975) conducted research on the extent of utilization of curanderos in the Pilsen community of Chicago. The residents of

the Pilsen community are predominantly Mexican American with a number of them being recent arrivals from Mexico. Ayala reported that between 60 to 80 percent of the residents of Pilsen utilized curanderos for some form of illness. The nature of the population of the Pilsen community should be stressed as it is possible that utilization of curanderos is more widespread among recent arrivals from Mexico.

Martinez & Martin (1966) provide an excellent summary of the etiology, symptoms and treatment of the commonly cited Mexican folk illnesses; mal ojo (evil eye), susto (fright), empacho (food-blocked intestine) and mal puesto (hex). Martinez & Martin also report a field study of 75 Mexican American housewives in which the respondents revealed considerable knowledge of these illnesses and their treatment. The authors concluded that although belief in these folk illnesses remains widespread, their respondents manifested a compartmentalized form of participation in services, such that treatment for folk illnesses is sought from curanderos and senoras, while other medical or emotional problems are taken to physicians. The data confirming the importance of curanderismo as an explanation for the underutilization phenomenon are meager. There do exist some data that curanderismo as an explanation for the underutilization phenomenon may be overemphasized, particularly in this decade (Edgerton, Karno & Fernandez, 1970; Keefe, Padilla, & Carlos, 1979). In two studies conducted in California, the following results were obtained:

...curanderos do not appear to be used with any frequency even for physical problems; in comparison to other sources of emotional support, they are of negligible importance for the Mexican Americans in our sample. Our data thus confirm the work of Edgerton, Karno, and Fernandez (1970) who find a decline in curanderismo in Los Angeles. (Keefe, Padilla & Carlos, 1979, p. 150)

The key issue here is not to prove or disprove the existence of the Mexican American's belief in folk illness, but rather to determine the impact of these beliefs on the utilization of traditional mental health services. It is possible that the impact of curanderismo is a regional issue, with differences tied to local norms and the availability of formal health/mental health facilities and of locally based healers. Nevertheless, without further data, the viability of curanderismo as an explanation for underutilization remains doubtful.

The sixth variation in Karno & Edgerton's list proposes that Mexican Americans avoid the mental health establishment for fear of their own or their loved one's deportation. This explanation does not have any substantial data to support it. Since most illegal aliens are also asserted to avoid census counts and since the majority of utilization studies have used census data to calculate the base population for utilization rates, illegal aliens' presence or absence should have a negligible influence on the existence of the underutilization phenomenon cited in the literature. In fact, this particular explanation tends to smack of racism since the vast majority of Mexican Americans residing in the United States are legal citizens. Once again, the point

must be made that this explanation places the onus for underutilization on a characteristic of Mexican Americans (in this case, their supposed illegal status).

The final, as yet undiscussed variations offered by Karno & Edgerton (7 and 3 in the list quoted earlier) are in many ways so similar that they will be discussed together. These explanations propose that there exists an incompatibility between the mental health needs of Mexican Americans and the methods of service delivery utilized by mental health facilities. The explanation described in number 7 is essentially a narrow version of this generic explanation, in that it places the primary incompatibility on the lack of bilingual caregivers. The explanation in Karno & Edgerton's list which was earlier labeled number 3, on the other hand, cites examples of high costs, inaccessible location of services, inappropriate hours of operation, and a general lack of respect for the client on the part of the caregivers as the reasons for underutilization of services. It is the present author's opinion that this generic explanation of incompatibilities between the client and the service modality is the most likely explanation for the underutilization phenomenon.

III. INCOMPATIBILITIES OF SERVICES AS AN EXPLANATION FOR UNDERUTILIZATION

The research of Karno & Edgerton also appears to have led the authors to a conclusion in line with the concept of incompatibilities:

We believe the underrepresentation for Mexican Americans in psychiatric facilities is to be accounted for by a complex of social and cultural factors. These factors having different weightings in their relative influence. Some of the heavily weighted factors include: a formidable language barrier... (and) the self-esteem reducing nature of agency-client contacts experienced by the Mexican American community itself. (Karno & Edgerton, 1969, p. 237)

Morales (1978) indicates his support of the incompatibilities hypothesis and provides an excellent case for its viability:

On close examination of the facts, it is apparent that the prevalent patterns of underutilization are primarily the result of culturally irrelevant services which are being provided to the Mexican American (Burrue! & Chavez, 1974). Available statistics provide support for this explanation. For instance, there is evidence that specific mental health programs which provide culturally relevant services tend to show an increase in the rate of utilization by Mexican Americans and, more astonishingly, in some instances there is evidence of overutilization. (Morales, 1978, p. 125)

The theoretical concept of incompatibilities between the Mexican American and the mental health service delivery system will form the core of the discussion to follow. Numerous

researchers across a range of disciplines have developed the concept of incompatibility in one form or another. For example, organizational theorists have stressed the importance of a compatibility between organizations and their environments (Burns & Stalker, 1961; Kast & Rosenzweig, 1973). An example of the concept of incompatibilities applied to education will be discussed in more detail as it contains considerable applicability to the delivery of mental health services.

In a paper, entitled "The Theory of Incompatibilities," Cardenas & Cardenas (1977) present a model which asserts that when the needs of the client and/or his or her internal characteristics are incompatible with the methods of service being dispensed by an institution, for all practical purposes the service is irrelevant and may even be detrimental to the client. The model proposes that in order to remedy this situation, the points of incompatibility at the interface between the client and service delivery system must be identified and eliminated. It should be noted that within such a framework of analysis no statement is being made as to the general utility of a particular method of service delivery, only that this system of service may not be appropriate with some clients.

Cardenas & Cardenas' theory presents examples of areas of incompatibilities focusing on the strains of poverty, culture, language, mobility and societal perceptions of the individuals. These are viewed as primary variables which tend in our society to place the Mexican American individual in a much different

psycho-social situation from the one experienced by his/her Anglo counterpart. The authors emphasize that no one of these factors alone is sufficient for understanding the incompatibilities between service provision and Mexican American needs. Instead, it is the interaction of factors which is of critical importance. This point is of particular theoretical importance in that few individuals would debate that many of the factors listed by Cardenas & Cardenas also affect the lives of many Anglos. Again, the crucial differentiation is that few Anglos experience these factors simultaneously, as do many Mexican Americans.

Cardenas & Cardenas suggest that subsequent to the identification of the primary areas of incompatibility, one must decide how to intervene for change. A generally tried method is to change the client so that he/she fits into the mold necessary for the model of service utilized, thus necessitating little or no change on the part of the caregiver. This method also contains the advantage that if and when it proves unsuccessful, the majority of blame for failure can be placed on the individual rather than on the system of care.

As an example, consider the possible effects on a mental health center that is designed to dispense psychotherapy but which is suddenly faced with an onslaught of Mexican American clients seeking relatively rapid solutions to their problems. It should be noted that their desire for quick solutions may be perfectly adaptive to their personal and lifestyle constraints (that is, if you know this may be the last time your boss lets you off work to go to the center, you would be more disposed to seek a

final solution during the one visit). The reactions of this hypothetical center to the situation may be numerous: 1) set up a community and client educational program to teach these individuals how to use psychotherapy (this strategy attempts to change the client to fit the service; note also this approach does little for our client who no longer could take off from work); 2) change the nature of the service provided to emphasize "crisis intervention" approaches, and assist clients in achieving access to these services (like helping the job-constrained client by either talking with his/her boss, or offering services to him/her at a more convenient time). The latter/second strategy in many cases requires a re-orientation on the part of staff as to the goals and methods of service delivery provided by the community mental health centers. Whereas machinery in a factory can be relatively easily re-tooled to output a different product (at a price), professionals are less often quickly adapted or even open to change.

Yet a third possible tactic our hypothetical center might take is to use both of the above strategies simultaneously which might prove to be an excellent alternative. The point of this example is that it is entirely possible that the solution generally chosen by mental health delivery systems is to emphasize the option of insisting that the client change or adapt to fit the service. Solutions which demand that the individual fit the system have proved ineffective across a range of social services and have, in many cases, proved to be organizationally maladaptive.

IV. THE CONCEPT OF UNDERUTILIZATION IN RESEARCH

The phenomenon of underutilization of mental health services by Mexican Americans as described in the literature has been discussed to this point without critically assessing some of the conceptual problems associated with the concept of underutilization per se. Three of these conceptual problems will be discussed in this section: 1) the assumption that need for services is being assessed or that need is randomly distributed in the population, 2) the assumption that all ethnic groups possess relatively equal access to services and 3) that equal utilization is equivalent to equal care.

An implicit assumption made in much of the research on the underutilization phenomenon is that the need for services is relatively equivalent across ethnic groups. Hence, when ten percent of the population in an area is Mexican American and eighty percent Anglo, researchers expect equivalent percentages in the client population of whatever facility is being studied.

Rabkin & Struening (1976) having conducted a review of the literature pertaining to the influence of ethnicity in relation to the prevalence and incidence of mental illness concluded:

It is generally acknowledged that psychiatric disorders are not distributed throughout populations, but tend to be concentrated within definable sub-groups. The major dimensions historically associated with such variations are those of ethnicity, social class and immigration... (Rabkin & Struening, 1976)

Hollingshead & Redlich (1958), in support of Rabkin & Struening's conclusion, have pointed out that low income groups use and need services in far greater amounts than their higher income counterparts. Also, census data and other research findings have consistently documented Mexican Americans as having a lower per capita income than Anglos (U.S. Bureau of the Census, 1976; Montiel, 1978). Using the hypothetical population above of ten per cent and eighty per cent, it is apparent given the above factors that numerical equivalency could be obtained and underutilization (with reference to actual need) will probably still exist. This line of reasoning is seldom stated, because in most of the underutilization studies numerical equivalency is not achieved. Thus, additional need for services by Mexican Americans only accentuates the argument. Nevertheless, researchers who find equivalent numerical rates of utilization between Anglos and Mexican Americans must be cautious in interpreting their results as a case for equal access and use of services by Mexican Americans. To circumvent this problem, the researcher would need to adjust his/her figures for the potential of a differentially greater need for services in the Mexican American community. An adjustment of this type will be extremely difficult to generate given our present understanding of the concept of need for mental health services and its measurement.

A second assumption in the utilization rate research is that all ethnic groups possess relatively similar accessibility to mental health services. The viability of this assumption is questionable simply on the basis of economics. Mexican Americans

being highly represented in the lower income strata relative to their Anglo counterparts can rarely afford the fees charged by private practitioners; assuming such practitioners are available in their communities. In addition, a study conducted by Valdez (1980) of the distribution of community mental health centers in Texas in relation to the Mexican American population led the author to conclude:

Regarding...whether or not CMHC services are accessible to SL/SS (Spanish Language/Spanish Surnamed) folk within the same region the center is located in, the answer is an overwhelming no. The regions of the state that are predominantly Anglo have more CMHCs in smaller regions than those regions that are predominantly SL/SS. (Valdez, 1980, p. 32)

Finally, the third assumption made by most underutilization studies is that the numerical indication of a client in services is roughly equivalent across clients in type and length of service provided. As an example, if we have ten Mexican American first admissions to a center for services that logged an average of only two visits, they are numerically equivalent (ten cases) to ten Anglos that may have logged an average of seven visits (also ten cases). Clearly, the extent or length of care was not equivalent, and yet utilization rate data would not indicate to researchers the difference between these two groups. This situation, of course, would only present a problem to researchers, if in fact, there were differential forms or use of services by Mexican Americans, which in fact appears to be the case.

Yamamoto, James, & Palley (1968) studied the mental health system of care of 594 men and women, 53 of whom were Mexican American. Their findings indicated that, compared to their Anglo counterparts, the Mexican American clients were referred for individual and group therapy less often and received less lengthy and intensive treatment. Karno (1966) reviewed the case records of the Neuropsychiatric Institute at UCLA for Negro, Mexican American and Anglo patients and confirmed the findings of Yamamoto, James & Palley (1968). Karno concluded that "ethnic patients who are accepted for treatment receive less and shorter psychotherapy than do non-ethnic patients."

Sue, Allen & Conaway (1978) utilized data from 17 community mental health facilities in Washington State to review the type of care provided to 13,450 clients, of whom 83 were Mexican American. The researchers reported similar types of care rendered to Mexican American clients as compared with Anglos, but again pointed out that the former seem to terminate services sooner: "...Chicanos, were less likely to return than Anglos. Chicanos also averaged fewer sessions. (Sue, Allen & Conaway, 1978)

A study by Andrulis (1977) of a fifty percent sample of terminated cases in a Texas community mental health center also found ethnicity to be a key factor in the delivery and use of services. Andrulis reports that "between their diagnoses and discharge, certain factors caused Mexican Americans...to drop out prematurely...these clients consequently obtained fewer referrals back into the community..."

Finally, results of a study conducted by Kahn & Heiman (1978) of 356 cases seen by a mental health center in the Southwest, shed some light on just how dramatic the drop out rate is for Mexican Americans. Eighty percent of Kahn & Heiman's sample was Mexican American. The authors reported, "...75% of the cases were seen for a single therapy contact, 15% had two therapy interviews while 10% had three or more."

Each of the above researchers appears to concur with the conclusion of a major review of the effect of class upon mental health treatment:

...psychiatrists refer to therapy persons most like themselves, that is, whites rather than non-whites and those in the upper rather than in the lower income range...

...socioeconomic status correlates significantly and negatively with acceptance for and duration of individual psychotherapy... (Lorion, 1973, p. 266)

Lorion's conclusions are further substantiated by research conducted by Miranda, Anclujo, Caballero, Guerro & Ramos (1976). Miranda et al. attempted to differentiate between those clients who remained in treatment and clients who terminated after only a few visits. Miranda et al. reported that those clients which remained in treatment for a minimum of five sessions "demonstrated higher levels of both psychological and behavioral acculturation relative to those...prematurely terminating therapy." This study appears to support the contention that the more the client is "like" his or her therapist, the greater the likelihood that the client will remain in treatment. Also,

consistent with Lorion's conclusion is the work of Leninger (1971) who reported that doctors who could not speak Spanish and were not familiar with the culture of the Mexican American felt uncomfortable with treating these clients. These feelings on the part of therapists held implications for the type of care provided such that prescribing pills and shock treatments became the primary mode of treatment for these clients.

Given these studies, the assumption discussed earlier of equivalent percentage representation being taken as tantamount to equivalent use of services across ethnic groups is clearly a problem, if not a fallacy, in the "utilization" research. Again, the problem presented to researchers is that, along with utilization rate data, type of care received must be measured and taken into account. This is particularly true when numerically equivalent utilization rates across ethnic groups are obtained.

An additional fallacy which saturates much of the literature is that the provision of more services in the Mexican American community is of itself the desired goal. In fact, the evidence is far from conclusive that the present cadre of treatments offered in traditional mental health facilities are beneficial to Mexican Americans. Barrera (1978) suggests "the availability of relevant effective services could likely increase utilization" (emphasis added). The following quotation from Montiel (1978) indicates the author's agreement with Barrera's conclusion:

The unequal access to mental health services is only part of the problem. If, all of a sudden, Chicanos flooded existing mental health facilities, the inadequate and faulty knowledge about them would result in services that would be inconsistent with their needs and wishes. It is the control of the diagnostic and treatment paradigms more than the underutilization of mental health services that alarms many Chicanos.

The problem caused by questioning the utility of treatment is that researchers are forced to turn some of their attention to the more difficult issue of designing culturally appropriate treatment modalities rather than the simplistic body count research of the underutilization phenomenon. Nevertheless, without substantial improvements in the technology of care available to mental health institutions, their ability to provide appropriate and effective services to all clients will remain marginal at best (Perrow, 1965).

The focus by many researchers on the rates of utilization rather than the quality of care may soon prove to be quite maladaptive to the long-range improvement of mental health services for Mexican Americans. The arguments demanding equity in the accessibility, availability and acceptability of services for Mexican Americans which have spawned from the underutilization studies have helped to alleviate some of the previous inequities. But there is a catch to this approach that may soon be faced. The difficulty lies in research findings and mental health agency reports which document equal rates of utilization by Mexican Americans (numerically) and then present this as evidence of the equal access, availability and use of care by Mexican Americans.

By stressing the importance of numerical equivalency of rates, many Mexican American researchers may have created a monster that will not be easily caged.

If as Barrera (1978) states, striving for equal rates of utilization by Mexican-Americans should not be the focal point of advocacy for the improvement of mental health services to this ethnic group, then the critical issue becomes: what is the focal point? Numerous words such as equity, equality, equivalence and parity of services have been proposed as possible focal points for advocacy efforts. Yet each of these words carries an immense number of connotations.

It might prove useful to examine some of these words and the difficulties they entail. Webster defines equity as "fairness, impartiality and justice." Although fairness and justice are useful goals in advocating for the improvement of mental health services, it is highly questionable that a state of impartiality is being sought. Particularly, if one believes that different individuals have different needs and should receive appropriately tailored services. Equivalence is defined by Webster as "equality of quantity, value, force, meaning, etc." Equivalence is in fact nearly perfect, except that it is open to a fairly broad range of interpretation. The most problematic interpretation with regard to the delivery of mental health services to Mexican Americans, is that equivalence might be defined as an equal number (quantity) of hours with an Anglo psychotherapist, which costs the agency or taxpayer a specific amount (value). It

appears that what is actually being sought is the provision of services which are compatible with the individual needs of each client. Clearly, such a goal is conceivable theoretically but is somewhat complicated to implement. Nevertheless, we must avoid getting too entrenched in an argument which discusses the complexity of developing completely individualized services, and rather view this as a goal we attempt to approximate as closely as possible. By attempting to provide services which are compatible with each individual's needs, we begin to ensure that these services will be relevant, valuable and effective for the client. Nevertheless, it should be noted that the implementation of such an approach would require: 1) a substantial shift from the medical model of service delivery which implies the adaptation of the client to the mode of care rather than the provider adapting him or herself to the client, 2) a shift in the locus of the definition of the client's problems away from the model of the therapist as "expert" to the client's self-assessment of his or her needs, and 3) an organizational shift on the part of community mental health centers to foster innovation rather than seeking standardization of care.

As such, what is now required is a two-tier approach as the focus of advocacy efforts for the improvement of mental health service delivery, with the first tier being labeled as a striving to achieve equity of services for all individuals which implies equal accessibility and availability of services. The second tier is then an attempt to achieve compatibility of services (the provision of acceptable, appropriate, quality care using the

client's individual needs as the point of reference). Such a two-tier approach should make clear the objectives being sought which include not only equity of services but also issues of quality (with quality being assessed by the ability of a modality to meet the clients needs) and appropriate care or compatibility of services. The majority of the "underutilization" studies in the literature have investigated the first tier described above and only hinted (usually at the end of the study) that future research must investigate the second tier. If the issues involved in the second tier are not addressed, Mexican Americans will continue to exhibit premature termination of treatment and underutilization of services (due to their awareness of the lack of utility in the treatments provided). The achievement of compatibility between mental health services and Mexican Americans will require the development of a cadre of culturally appropriate treatment modalities which match treatment to the unique needs of each client. In this way each client would receive compatible services such that the service would validly and effectively meet the client's individual needs.

For example, Burrue! & Chavez (1974) reporting on the methods of service delivery utilized by La Frontera, a mental health outpatient center in Tucson, indicated that the center was substantially utilized by the Mexican American community. In addition, greater utilization was related to the attempts of the service delivery system to become compatible with the needs of their clients. Burrue! & Chavez noted that La Frontera utilized no complicated forms or long-waiting lists. In addition, the

ability to pay was not a prerequisite for services, and a very informal atmosphere prevails at the center. Even more importantly, the providers at the center clearly attempt to provide services compatible with the needs of their clients as is noted in the following quotation:

Although it can be said that the direct treatment approaches we utilize fall within the traditional model, we modify them to meet the needs of the client. For example, the mental discomfort a person may be experiencing may be attributed to environmental stress. Subsequent to a differential diagnosis, we may find that a psychotherapeutic approach may not be appropriate. Instead, we attempt to deal with the current situation by manipulating the environment, mobilizing community resources, being advocates for the client and by providing a tangible service. Also, we often deviate from conventional approaches such as length of contacts with clients--not abiding strictly with the fifty minute hour or weekly interviews, by making home visits and/or telephone calls.

Many of our clients use us on a crisis to crisis (or emergency) basis, because it is very difficult for many to relate to consistent, hourly therapy sessions which would deal with strengthening their ability to cope with crisis. Instead of insisting that they engage in regular therapy, each time they contact us we try to help them learn other ways of handling their problems. This takes longer and it may not seem as effective as other approaches on the face of it, but it seems to work better with these patients, and most important, they can relate to it. (Burrue! & Chavez, 1974, p. 118).

Although some excellent efforts such as those cited above have begun, the formal development of culturally appropriate treatment modalities into a coherent, applicable system of care which is responsive to, and useful in, dealing with the mental health

problems of Mexican Americans is not yet available. This situation can be rapidly remedied if researchers begin to concentrate on the issue of compatibility of services. These modalities, once developed, must then be implemented by appropriately trained staff. Such an implementation would no doubt require the use of considerable numbers of bilingual, Mexican American, mental health care-givers. This may prove to be a problem as there currently exist very few Mexican American professional mental health care-givers and few are currently being produced by institutions of higher education. Clearly, the problems and issues posed in trying to achieve compatibility of services are different from those encountered in the equity of services issue. Nevertheless, as stated earlier, both of these concepts must be addressed in parallel efforts if real improvements in the delivery of mental health services to Mexican Americans are to be achieved.

V. Recommendations and Models Found in the Literature for Enhancing the Utilization of Mental Health Services by Mexican Americans

A number of the researchers previously mentioned have offered a range of recommendations for improving the delivery of mental health services to Mexican Americans and thereby increasing utilization of services (Padilla, Ruiz & Alvarez, 1975; Sue, 1977; Morales, 1971; Barrera, 1978). In addition, the participants of three major conferences dealing with the mental health needs of Mexican Americans in the Southwest have also

articulated recommendations for change (Brusco & Ramirez, 1979; Duran, 1975; Souflee & Valdez, 1978). Although, it has rarely been explicitly stated, the majority of recommendations found in the literature deal with making the system of care more compatible with its clients. The following list is not exhaustive but summarizes and is representative of the recommendations proposed: 1) a greater emphasis on prevention of mental illness; 2) the development of non-traditional approaches to treatment; 3) an expansion of research efforts in the development of culturally relevant treatment modalities; 4) the more extensive utilization of bilingual-bicultural staff; 5) the establishment of a stable funding base for facilities with special funds being earmarked for services dealing specifically with the mental health needs of Mexican Americans; and 6) modification of the organizational structure and practices of mental health facilities to meet more adequately the needs of Mexican American clients.

Another characteristic of each of these recommendations is the complexity of implementation they would entail. And yet, it is precisely because of previous failures to address this complexity that past attempts to improve mental health services substantially have proved inadequate.

The concept of primary prevention was critical to the birth of the community mental health movement and yet, to a large degree, the concept of prevention has been neglected in terms of implementation (Musto, 1975). The disciplines of community psy-

chology and community psychiatry were spawned in the disenchantment of many mental health service providers who looked upon traditional treatment modalities as dealing with casualties of an overly stressful society. An emphasis on the needs of children and mentally healthy individuals was proposed as a method of slowing the rate of casualties seen by traditional mental health service providers.

The critical problems with the concept of primary prevention were: 1) the lack of a technology for improving a community's mental health (as opposed to treating mental illness for which we have developed some operational definitions and treatment modalities however, crude these may be); and 2) the inability to show conclusively the results of one's intervention efforts. This later concern is of particular importance in a culture which demands cost effectiveness (it is far easier to document that ten individuals were provided with a pill, than it is to show that ten children were prevented from becoming drug addicts due to an intervention in the community). These difficulties have caused the majority of service providers to shelve the issue of primary prevention. Since a large proportion of the Mexican American population in this country is under the age of 18 and is experiencing tremendously stressful life conditions, the issue of primary prevention is critical. As other researchers have stated, if the Mexican American community is to be truly impacted by mental health service providers, these providers must reassert their emphasis on prevention (Padilla, 1976).

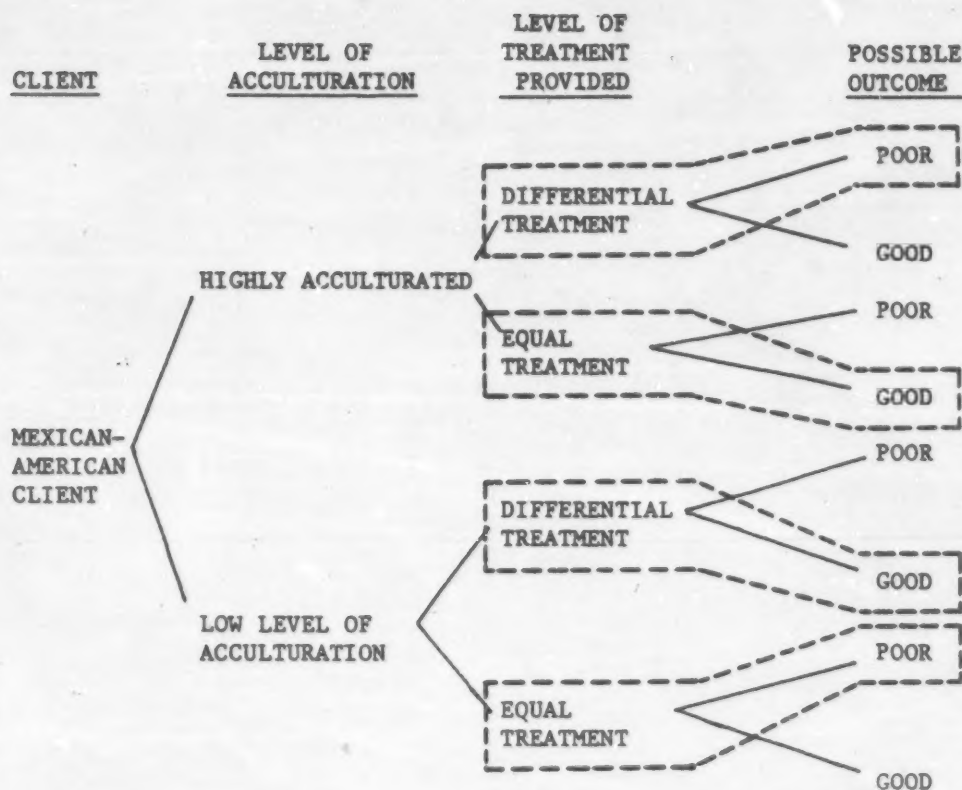
Along with the need for an emphasis on primary prevention, there exist recommendations for more non-traditional approaches to delivering mental health service to Mexican Americans (Morales, 1978). It has been customary that the institutional approaches to treatment do not appear to be working well with Mexican Americans. In fact, the utility of these methods with most groups remains in question. Perrow (1965), for example, argues that one of the major problems encountered by mental health service providers and organizations is that there exists at best only a crude technology of treatment. Exacerbating this problem for Mexican Americans is the lack of culturally relevant treatment modalities. Although some areas of psychology and psychiatry have advanced remarkably, other areas, particularly in the treatment of chronic mental illness, have progressed quite slowly, with psychotropic drugs being the only major advance in the recent past. Two of the primary factors contributing to the lack of advancement of the technology in mental health is the paucity of innovation and the lack of recognition of inter and intra group diversity. Pethia (1970) provides a model for the improvement of educational services in institutions for higher education which stresses the critical role of continuous innovation. In an area where a fairly effective technology exists, the gradual refinement of these techniques is sufficient. But when only a crude technology of services exists, the continuous experimentation with new approaches becomes critical. One of the unfortunate assumptions made by many service providers and administrators of mental health agencies is that they are

functioning with a fairly effective technology. Whereas, in fact, for all the progress we have made in psychology and psychiatry we are a considerable distance from the attainment of the kind of viable technologies available in business and medicine. The situation facing mental health simply demands a mentality of innovation. Nevertheless, while innovation is easily funded in business, it is generally difficult to obtain funds for innovative programs in the public human service delivery system.

Part of the problem has stemmed from the simplistic approaches used in the past to trace the beginnings of mental illnesses in groups and the lack of recognition for differences within and between cultural groups. For example, the conglomeration of the culture and mental health needs of Mexican Americans along with those of Cubans, Puerto Ricans and other Latin Americans under the term Hispanic causes some distortion. Although each of these groups share many common characteristics, they also exhibit considerable differences which must be accounted for in the development of responsive treatment systems for each group - and each individual. Even within groups such as the Mexican Americans, there exists considerable diversity across such variables as region, religion, education, income and acculturation. It is entirely possible that with highly acculturated Mexican Americans, treatment modalities designed for middle class Anglos might be quite compatible. And yet with the less acculturated Mexican American, these same treatment modalities might fail miserably. Sue (1977) emphasizes the critical importance of matching the type of client to the proper

method of care. Figure 1 represents an example of an expansion by the present author of Sue's conceptualization of matching clients to treatment needs, in this case using acculturation as a possible variable of difference in clients.

FIGURE 1



BEST COPY AVAILABLE

The dotted lines indicate possible outcomes encountered, with the critical issue being that neither differential nor equivalent provision of services should of itself be looked upon as a goal. Rather the needs of the client should dictate the mode of care provided, and a compatibility of treatment with the client's needs should be emphasized.

Yet another recommendation proposed in the literature calls for extensive utilization of bilingual-bicultural staff (Torrey, 1969; Brusco & Ramirez, 1979). Torrey (1969) expresses the concern that "whenever therapists from one culture diagnose and prescribe treatment for patients from another culture there is an inherent probability of professional misjudgment." Torrey's statement appears to be supported in the literature.

Marcos, Alpert, Urcuyo & Kesselman (1973) found that bilingual Spanish-speaking clients were rated as more pathological when interviews were conducted in English as opposed to Spanish. In addition to the concern over language barriers is the issue of the delivery system's cultural sensitivity. Padilla, Ruiz & Alvarez (1975) state:

Crash programs in Spanish-language acquisition for monolingual, English-speaking professionals are a partial solution...But language skill is not enough...the mental health professional must be knowledgeable about the culture... (Padilla, Ruiz & Alvarez 1975, p. 901)

This type of research presents excellent support for the need for more bilingual-bicultural service providers in mental health. Nevertheless, data from the President's Commission on Mental Health indicate:

Psychiatry: In 1971, the American Psychiatric Association included 544 Spanish-Surnamed members (3.4% of the total APA membership). Of these, however, only 85 (.54% of total membership) were United States residents. Of the psychiatrists in training, the 1976 APA directory listed only 43 Chicanos. However, some of these physicians were incorrectly identified and are actually Mexican citizens.

Psychology: In 1973 there were a total of 115 Hispanic psychologists in the United States (.5% of the known total of 22,501). In addition, 31 Hispanics obtained Ph.D.'s in clinical psychology during the period FY 1973-FY 1976 (.9% of the total 3,213 doctorates awarded in this discipline). Finally, Hispanic representation among first-year graduate students in clinical psychology programs has decreased from 3.4% (37/1, 127) in 1972 to 2.2% (26/1, 182) in 1976.

Social work: During the period 1969-1974, there were a total of 42,484 graduates from accredited M.S.W. programs. Of these, 1,681 (4%) were of Hispanic origin. In 1974 there were a total of 16,590 graduate students enrolled, of whom 712 (4.3%) were Hispanic. (p. 912)

Although these data clearly indicate the need to encourage the rapid training of a massive number of Hispanics in the field of mental health, a concerted initiative on the part of the mental health establishment and institutions of higher education appears to be lacking.

If community mental health centers are to endeavor to improve the quality and responsiveness of their services for Mexican Americans, they must: (1) have a stable funding base, and (2) allocate special funds to be earmarked for meeting the needs of Mexican Americans. Yet, currently, increasing numbers of centers are facing decreased funding from the federal level, and they have not yet established a strong basis of local support. This situation leaves the state government in a pivotal role in either continuing the development of community mental health centers as initially proposed at the federal level (that is, with an emphasis on mental health and on prevention efforts) or by modifying the role of the centers and possibly even ending their existence.

This period of growing reliance on state aid is already evidenced in the majority of community mental health mental retardation centers in Texas. As this transition of funding responsibility and control occurs, it will be of primary importance to examine the nature of the concurrent shift in interpretation of the community mental health center's role. If Texas decides to make a firm commitment to meeting the mental health needs of Mexican Americans, what is required is an allocation of state funds specifically earmarked for: (1) the development of culturally relevant treatment modalities, and (2) the improvement of the system of delivery of mental health services to Mexican Americans.

There currently exists a sorely needed emphasis on the development of management and organizational effectiveness in the area of mental health as can be documented by the increasing numbers of workshops and conferences held on this topic in the recent past. Nevertheless, much of what has been learned in organizational theory and management has not been applied to mental health organizations. For example, in the terminology of organizational theory, a community mental health center can be characterized as a highly organic (constantly changing) system. This system is embedded in a very turbulent task environment which implies that external forces affecting the center are constantly in flux. Examples of the turbulence in the task environment include the relatively rapid changes in funding, legislation and goals which are common to most community mental health centers. In fact, the inability of centers to reach any form of stable state is often discussed as a primary problem.

Such a system, in organizational theory, should make every effort to interface (exchange massive amounts of information) with its environment (in this case clients, other consumers, legislators, etc.). Many centers take the direct opposite tactic, however, of trying to minimize the information input from the environment -- which is an excellent tactic if one is managing a fairly mechanistic system that exists in a stable environment (such as an assembly plant in which the same routine task is performed over and over). Indeed, it is possible that one of the primary areas of difficulty is that many centers are being

managed on the whole through the use of a mechanistic business model rather than placing primary emphasis on the development of an organic humanistic model.

It should be noted that within any organization both forms of management are required and yet the character of an organization can often lean in one direction over the other. What is being proposed is that the management of any community mental health center must make extremely clear distinctions between those segments of center operations that can be handled via a set of standard operating procedures, or a mechanistic mode, and those segments which require an organic model of management that places a premium on innovation, adaptability to change and tolerance for ambiguity. In many centers, the demand for better management is too often answered with a shift toward a predominate use of the mechanistic mode of management. If such a problem exists it carries considerable implications: 1) standardization rather than innovation can become the watchword of the organization; 2) the acknowledgement of uniqueness in clients will need to be avoided to insure standardization; and 3) the need to exchange information with numerous external forces ("boundary spanning" in organizational literature) will not be adequately acknowledged, whereas in fact, this activity is critical to the effectiveness of an organic organization (Osborn & Hunt, 1974). An example of the inability of many centers to span their boundaries adequately for information and support is

evident in their inability to involve the community in their operations which has led in some cases to a low level of community support in the area of funding.

As discussed earlier, the lack of technology found in mental health service delivery systems clearly affects the capacities of these systems to perform their role properly. For example, in the realm of mental health, it can be asserted that the end product desired (at least in theory) is to bring about a change in the psychodynamic structure of the client, such that he or she will be competent to cope effectively with life. Any brief review of the literature in the area of mental health will immediately indicate that there is only a crude technology available for performing such a transformation that is effective in a consistent and cost-effective manner. Without the technology for bringing about consistent and constructive changes in clients and for an evaluation of these changes, it becomes very difficult to to assess the actual results obtained from the system. It is also clear from a number of areas of literature on human problems that we as social scientists and administrators are not exactly sure nor can we agree (indicative of a goal setting problem) on what are the desired results of the system.

The mental health establishment faces tremendous organizational problems and these must be addressed if the needs of clients are to be met adequately. Logistical and procedural concerns must also be addressed, as Padilla points out in the following quote:

New centers should be situated in the appropriate neighborhoods. Centers established at a distance from the target population must "attract" clientele, perhaps by following a business model. Possibilities include arranging transportation...providing child-care facilities for patients...and encouraging regular attendance at therapy sessions (e.g., through reduced fees or by remaining open "after hours"). (Padilla, Ruiz & Alvarez, 1975, p. 903)

Padilla's suggestions are consistent with the mode of operation which is established by a flexible responsive system (that is, an organic system). It should be noted that to suggest the promotion of organizational flexibility in community mental health centers is not a subjective preference but is rather, as organizational theory proposes, a necessity for their future survival, as well as for the improvement of services to all clients, including Mexican Americans.

Conclusion

To reiterate, the purpose of this paper was not to report exhaustively and describe all of the studies generally cited as dealing with underutilization. Rather the paper attempted to present the major issues and concepts involved in this body of literature. Four key points were stressed in the preceeding discussion.

First, the underutilization phenomenon is not a homogeneous finding in the literature, and in some cases, overutilization is found. This is particularly evident in service centers where an attempt has been made to provide clients with compatible services

in relation to their needs. Centers such as La Frontera in Tucson, Aliviance in El Paso, and the Community Mental Health Center in East Los Angeles have attempted to address the mental health needs of Mexican Americans. The higher rates of utilization by Mexican Americans in these centers provide considerable support for the idea that improvement of the quality, compatibility, availability and accessibility of services will lead to increased utilization.

Second, the concept of utilization itself is highly complex. Although the issue of underutilization of services, as operationalized in the majority of the literature, has led in many cases to the identification of gaps in services, the research methods used will necessitate considerable refinement. The concepts of "under" - or "over" - utilization are particularly difficult to interpret meaningfully in the absence of measures of need for services, accessibility of services and of the quality of services. In fact, researchers must be extremely careful not to carry the issue of numerical equivalency too far, as it is likely that there does exist both differential need for services across ethnic groups and differential quality of services.

Third, a review of the diverse explanations offered to explain the underutilization paradox suggests that the concept of the existence of incompatibilities between the service delivery system and clients seems to hold the most conceptual promise. The majority of the alternative explanations either have little or no supportive empirical evidence. It is also curious that the majority of the explanations offered for the existence of under-

utilization of mental health services by Mexican Americans take on a position which Ryan (1976) has termed "blaming the victim," that basically consists of placing the locus of any difficulty in the client and not in the system of service delivery.

Finally, a two-tier approach must be adopted in future research and advocacy efforts dealing with the improvement of mental health services for Mexican Americans. Such an approach would emphasize both the concept of equity (equal accessibility and availability of services) and the concept of compatibility between the needs of each client and the services provided (the provision of appropriate and acceptable services). This two-tier approach should be seen as a goal to be achieved, as opposed to considering it an existing methodology. Indeed, many research and conceptual issues must be resolved before such an approach will be easily implemented.

Taken together, these four points lead to the conclusion that future efforts to understand the utilization of mental health services or the organizational provision of services will require the adoption of a system's perspective in the research. Indeed, many of the studies cited in this paper examine only an isolated segment of a much broader problem. Though the integration of these segments into a coherent whole is useful, we must begin to build an awareness within ourselves that if the issues of equity and compatibility of services are to be addressed, total systems (involving communities, funding agencies, service facilities, providers, clients, etc.) must be studied. The

literature cited herein contains a vast array of critical variables which interrelate in a number of diverse configurations, such that each mental health center and community present a unique set of conditions and situations. To begin to comprehend and design strategies for the alleviation of problems and gaps in the delivery of services, particularly for Mexican Americans, a comprehensive analysis of the mental health delivery system must be conducted.

REFERENCES

- Andrulis, D. P. Ethnicity as a variable in the utilization and referral patterns of a comprehensive mental health center. Journal of Community Psychology, 1977, 5, 231-237.
- Ayala, P. Curanderismo. Paper presented to the staff of the Pilsen Mental Health Center, Chicago, Illinois, 1971. Community Mental Health Journal, 1975, 11, 145-154.
- Bachrach, L. L. Utilization of state and county mental hospitals by Spanish-Americans in 1972. (NIMH Division of Biometry, Statistical Note 116, DHEW Publication No. (ADM) 75-158). Washington, D.C.: U.S. Government Printing Office, 1975.
- Barrera, M. Mexican American mental health service utilization: A critical examination of some proposed variables. Community Mental Health Journal, 1978, 14(1), 35-45.
- Brusco, B. A. & Ramirez, D. G. Mental Health and Mexican Americans: Planning for the 80s. San Antonio: Intercultural Development Research Association, 1979.
- Burns, T. & Stalker, G. M. The Management of Innovation. London: Tavistock, 1961.
- Burrue, G. & Chavez, N. Mental health outpatient centers: Relevant or irrelevant to Mexican Americans? In A. B. Tulipan, C. L. Attneave, and E. Kingstone (Eds.), Beyond clinic walls. University, Al.: University of Alabama Press, POCA Perspectives 5, 1974.
- Cardenas, J. A. & Cardenas, B. The Theory of Incompatibilities: A Conceptual Framework for Responding to the Educational Needs of Mexican American Children. San Antonio: Intercultural Development Research Association, 1977.
- Casas, J. B. Applicability of a behavioral model in serving the mental health needs of the Mexican-American. In M. R. Miranda (Ed.), Psychotherapy with the Spanish-Speaking: Issues in research and service delivery. Los Angeles: Spanish Speaking Mental Health Research Center, UCLA, Monograph No. 3, 1976.
- Creson, D. L., McKinley, C., & Evans, R. Folk medicine in Mexican-American subculture. Diseases of the Nervous System, 1969, 30, 264-266.

- Cuellar, I. The utilization of mental health facilities by Mexican Americans: A test of the underutilization hypothesis. Unpublished doctoral dissertation. The University of Texas at Austin, 1977.
- Dohrenwend, B. P. Social status and psychological disorder. American Sociological Review, 1966, 31(1), 14-34.
- Duran, R. Salubridad Chicano: Su preservacion y mantenimiento. The Chicano plan for mental health. Denver: WICHE, 1975.
- Edgerton, R. B., Karno, M., & Fernandez, I. Curanderismo in the metropolis: The diminished role of folk psychiatry among Los Angeles Mexican-Americans. American Journal of Psychotherapy, 1970, 24, 124-134.
- Fiedler, F. P. Utilization, Staffing and Community Profiles: Community Mental Health Mental Retardation Centers in Texas. San Antonio: Intercultural Development Research Association, 1979.
- Flores, J. L. The utilization of a community mental health service by Mexican Americans. International Journal of Social Psychiatry, 1978, 24(4), 271-275.
- Giordano, J. & Giordano, G. P. Ethnicity and community mental health. Community Mental Health Review, 1976, 1(3), 1-26.
- Hollingshead, A. G. & Redlich, F. C. Social class and mental illness: A community study. New York: Wiley 1958.
- Jaco, E. G. Mental health of the Spanish Americans in Texas. In M. F. Opler (Ed.), Culture and mental health: Cross-cultural studies. New York: Macmillan Co., 1959.
- Jaco, E. G. The social epidemiology of mental disorders. New York: Russell Sage Foundation, 1960.
- Kahn, M. W. & Heiman, E. Factors associated with length of treatment in a barrio-neighborhood mental health service. International Journal of Social Psychiatry 1978, 24, 259-62.
- Karno, M. The enigma of ethnicity in a psychiatric clinic. Archives of General Psychiatry, 1966, 14, 516-520.
- Karno, M. & Edgerton, R. B. Perception of mental illness in a Mexican-American community. Archives of General Psychiatry, 1969, 20, 233-238.
- Karno, M. & Morales, A. A community mental health service for Mexican-Americans in a metropolis. In N. N. Wagner and M. J. Haug (Eds.), Chicanos: Social and psychological perspectives. Saint Louis: Mosby, 1971.

- Kast, F. E. & Rosenzweig, J. E. Contingency Views of Organization and Management. Chicago: Science Research Associates, Inc., 1973.
- Keefe, S. E., Padilla, A. M., & Carlos, M. L. The Mexican American extended family as an emotional support system. Human Organization, 1979, 38, 144-152.
- Kline, L. Y. Some factors in the psychiatric treatment of Spanish-Americans. American Journal of Psychiatry, 1969, 125, 1674-1681.
- Kiev, A. Curanderismo: Mexican-American folk psychiatry. New York: Free Press, 1968.
- Kruger, B. The relationship of ethnicity to utilization of community mental health centers (Doctoral dissertation, The University of Texas at Austin, 1974). Dissertation Abstracts International, 1974, 35, 2436-B. (University Microfilm No. 74-24887)
- Leninger, M. Some anthropological issues related to community mental health programs in the United States. Community Mental Health Journal, 1971, 7, 50-61.
- Lorion, R. P. Socioeconomic status and traditional treatment approaches reconsidered. Psychological Bulletin, 1973, 69, 263-270.
- Madsen, W. The Mexican-Americans of South Texas. New York: Holt, Rinehart and Winston, 1964.
- Madsen, W. Value conflicts and folk psychiatry in South Texas. In A. Kiev (Ed.), Magic, faith and healing. New York: The Free Press, 1964, 420-440.
- Marcos, L. R., Alpert, M., Urcuyo, L., & Kesselman, M. The effect of interview language on the evaluation of psychopathology in Spanish-American schizophrenic patients. American Journal of Psychiatry, 1973, 130, 549-553.
- Martinez, C. & Martin, H. W. Folk diseases among urban Mexican-Americans. Journal of the American Medical Association, 1966, 196, 161-164.
- Miranda, M. R., Anclujo, E., Caballero, I. L., Guerra, C. C. & Ramos, R. A. Mexican American dropouts in psychotherapy as related to level of acculturation. In Miranda M. R. (ed.) Psychotherapy with the Spanish-speaking Issues in Research and Service Delivery. Los Angeles: Spanish Speaking Mental Health Research Center, Monograph #3, 1976.

- Montiel, M. (Ed.), Hispanic families: Critical Issues for Policy and Programs in Human Services. Washington: National Coalition of Hispanic Mental Health and Human Service Organizations, 1978.
- Morales, A. The impact of class discrimination and white racism on the mental health of Mexican-Americans. In N. N. Wagner, & M. J. Haug (Eds.), Chicanos: Social and psychological perspectives. St. Louis: The C. V. Mosby Co., 1971.
- Morales, A. The need for non-traditional mental health programs in the barrio. In Casas, M. J., Keefe, S. E. Family and Mental Health in the Mexican American Community, Los Angeles: Spanish Speaking Mental Health Research Center, Monograph #7, 1978.
- Musto, D.F. Whatever happened to "Community Mental Health?" The Public Interest, 1975, 39 (Spring), 53-79.
- Osborn, R. & Hunt, J. Environment and organizational effectiveness. Administrative Science Quarterly, 1974, 14, 231-246.
- Padilla, A. M., Carlos, M. L., & Keefe, S. E. Mental health service utilization by Mexican-Americans: First year progress report. Santa Barbara, Calif.: University of California, Social Processes Research Institute, 1976.
- Padilla, A. M. & Ruiz, R. A. Latino mental health: A review of the literature. (DHEW Publication No. (HSM) 73-9143). Washington, D. C.: U. S. Government Printing Office, 1973.
- Padilla, A. M., Ruiz, R. A., & Alvarez, R. Community mental health services for the Spanish-speaking/surnamed population. American Psychologist, 1975, 30, 892-905.
- Papajohn, J. & Spiegel, J. Transactions in families. San Francisco: Jossey-Bass, 1975.
- Perrow, C. Hospitals: Technology, structure and goals, in James March (Ed.), Handbook of Organizations, Chicago: Rand McNally, 1965, Chap. 22.
- Pethia, R. F. Toward the design and management of purposive educational programs, Chapter 9 in University Management Models, 1970.
- Phillipus, M. J. Successful and unsuccessful approaches to mental health services for an urban Hispano-American population. Journal of Public Health, 1971, 61, 820-830.
- Pokorney, A. D. & Overall, J. E. Relationship of psychopathology to age, sex, ethnicity, education, and marital status in state hospital patients. Journal of Psychiatric Research, 1970, 7, 143-152.

- President's Commission on Mental Health. Task Panel Reports Submitted to the President's Commission on Mental Health, Vol. III, Washington, D.C.: U.S. Government Printing Office, 1978.
- Rabkin, J. & Struening, E. Ethnicity, social class and mental illness in New York City: A social area analysis of five ethnic groups. New York: Institute of Pluralism and Group Identity, American Jewish Committee, 1976.
- Ramirez, D. G. Underutilization of mental health services by Mexican Americans. Unpublished manuscript, 1979.
- Riessman, F., Pearl, L., & Cohen, J. (Eds.). The mental health of the poor. New York: The Free Press, 1964.
- Ryan, W. Blaming the Victim. New York: Vintage Books, 1976.
- Saenz, J. The value of a humanistic model in serving Hispanic families. In Montiel, M. (Ed.) Hispanic Families: Critical Issues for Policy and Programs in Human Services. Washington, D.C.: National Coalition of Hispanic Mental Health and Human Services Organizations, 1978.
- Sauna, V. D. Sociocultural aspects of psychotherapy and treatment: A review of the literature. In L. E. Abt & F. Bellak (Eds.), Progress in clinical psychology, Vol. 3. New York: Grune and Stratton, 1966.
- Souflee, F. & Valdez, G. Proceedings of the Texas - New Mexico Symposium on the Delivery of Mental Health to Mexican Americans. Houston: Chicano Training Center, 1978.
- Srole, L., Langer, T. S., Michael, S. T., Opler, M. K., & Rennie, T. A. C. Mental Health in the Metropolis, Vol. 1. New York: McGraw-Hill, 1962.
- Sue, S. Community mental health services to minority groups: some optimism some pessimism, American Psychologist, 1977, Vol., p. 616-624.
- Sue, S., Allen, D. B., and Conaway, L. The responsiveness and equality of mental health care to Chicanos and Native Americans. American Journal of Community Psychology, in press.
- Torrey, E. F. The case for the indigenous therapist. Archives of General Psychiatry, 1969, 20, 365-373.
- Torrey, E. F. The irrelevancy of traditional mental health services for urban Mexican Americans. Paper presented at the American-Orthopsychiatry Association, San Francisco, California, March, 1970.

- Torrey, E. F. The Mind Game: Witchdoctors and Psychiatrists. New York: Bantam Books, 1973.
- Trevino, F. M. & Bruhn, J. G. Incidence of mental illness in a Mexican American community. Psychiatric Annuals, 1977, 7:12.
- U.S. Bureau of the Census. Persons of Spanish Origin in the U.S.: March 1975 (CPR, Series P-20, No. 290). Washington, D.C.: Government Printing Office, 1976.
- Valdez, R. Location of the Community Mental Health Centers in Texas: Some Descriptions and Comparisons. San Antonio: Intercultural Development Research Association, 1980.
- Weclaw, R. V. The nature, prevalence and level of awareness of "Curanderismo" and some of its implications for community mental health. Community Mental Health Journal, 1975, 11, 145-154.
- Wignall, C. M. & Koppin, L. L. Mexican-American usage of state mental hospital facilities. Community Mental Health Journal, 1967, 3, 137-148.
- Yamamoto, J., James, Q. C., & Palley, N. Cultural problems in psychiatric therapy. Archives of General Psychiatry, 1968, 19, 45-49.

IDRA MENTAL HEALTH RESEARCH PROJECT

NATIONAL ADVISORY COMMITTEE

Carlos H. Arce, Ph.D.
Project Director
National Chicano Research Network
5080 Institute for Social Research
University of Michigan
Ann Arbor, MI 48106

Carmen Carrillo, Ph.D.
Director
City and County of San Francisco Community
Mental Health Services
Mission Mental Health Center
2940 16th St., Room 319
San Francisco, CA 94103

Floyd Martinez, Ph.D.
Executive Director
Boulder Community Mental Health Center
1333 Iris Ave.
Boulder, CO 80302

Amado M. Padilla, Ph.D.
Director
Spanish Speaking Mental Health Research Center
UCLA
Los Angeles, CA 90024

Marta Sotomayor, Ph.D.
Special Assistant to the Administrator
for Drug Abuse, Mental Health and Alcohol
5600 Fisher Lane
Rockville, MD 20857

Ernesto Suazo
Executive Director
New Mexico Council of Community Mental Health
Service
620 Camino de Salud, N.E.
Albuquerque, NM 87131

**IDRA MENTAL HEALTH RESEARCH PROJECT
STATE OF TEXAS ADVISORY COMMITTEE**

Shirley Camfield
Vice-President/Communications NHMA
1113 Roaring Spring Rd.
Fort Worth, Texas 76114
(817) 732-6133

Juan Chavira, Ph.D.
Dept. of Family Practice
University of Texas Health
Science Center
7703 Floyd Curl Drive
San Antonio, Texas 78284
(512) 223-6361 Ext. 496

Israel Cuellar, Ph.D.
Director Houston Hall
San Antonio State Hospital
P.O. Box 23310
Highland Hills Station
San Antonio, Texas 78223
(512) 532-8811 Ext. 491

John Estrada
Coordinator - Drug Abuse Services
El Paso Center for MHMR
720 E. Yandell
El Paso, Texas 79902
(915) 532-1481

Janie Farris
Bay Shore MHMR Center
2001 Cedar Bayou
Baytown, Texas 77520
(713) 427-8544

Adela G. Freymann
Division Director
Medical Assistance Program
City of Austin Health Dept.
1313 Sabine
Austin, Texas 78701
(512) 474-6581 Ext. 302

Fernando Galan, Ph.D.
Assistant Dean
Graduate School of Social Work
University of Houston
4800 Calhoun
Houston, Texas 77004
(713) 749-3814

Roberto Jimenez, M.D.
Director
Southwest Mental Health
Mental Retardation
2415 W. Southcross
San Antonio, Texas 78211
(512) 924-1411

Othon Medina
Registered Professional Engineer
1600 Globe
El Paso, Texas 79915
(915) 543-5357

Alfonso Mirabal
U.S. Dept. of Commerce
Bureau of the Census
1100 Commerce
Dallas, Texas 75202
(214) 767-0625

John Moore, II
Texas Dept. of Human Resources
P.O. Box 2960
Austin, Texas 78769
(512) 441-3355

Dolores Briones Ybarra
Legislative Aid
State Representative Paul Moreno's Office
2314 Montana
El Paso, Texas 79903
(915) 533-8767



To obtain a list of IDRA publications, write:

Intercultural Development Research Association
5835 Callaghan, Suite 350
San Antonio, Texas 78228
(512) 684-8180